

01712

MARYLAND

STATE DEPARTMENT OF HEALTH

1740

CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH COUNTY <i>Dorchester</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Dor.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Rhodesdale</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Rhodesdale</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>		STREET ADDRESS (If rural, give location) <i>1</i>	
3. NAME OF DECEASED (Type or Print) <i>George Edmund Adshead</i>		4. DATE OF DEATH (Month) <i>2</i> (Day) <i>12</i> (Year) <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <i>Married</i>	8. DATE OF BIRTH <i>11/15/1879</i>
9. AGE last birthday <i>86</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Auto Contractor (Ret) Gen Business</i>	
11. BIRTHPLACE (State or foreign country) <i>England</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George E. Adshead</i>		14. MOTHER'S MAIDEN NAME <i>Hanna Turner</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <i>East New Market, Md.</i>	
17. INFORMANT AND ADDRESS <i>Lawrence Adshead</i>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
422.1 Immediate cause		(a) <i>Chronic Myocardial Degeneration</i>		<i>10 yrs +</i>	
Antecedent cause(s)		(b) <i>General Arteriosclerosis</i>		<i>10 yrs +</i>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <i>1945</i> , to <i>1956</i> , that I last saw the deceased alive on <i>Feb 10</i> , 1956, and that death occurred at <i>6:00 A.M.</i> , from the causes and on the date stated above.					
SIGNATURE <i>W. Harrison</i>		(Degree or title) <i>MD</i>		ADDRESS <i>Hurlock Md.</i>	
DATE SIGNED <i>2/14/56</i>					
23. BURIAL, CREMATION REMOVAL (Specify)		DATE <i>2/14/56</i>		NAME OF CEMETERY OR CREMATORY <i>East New Market</i>	
LOCATION (City, town, or county) <i>East New Market, Md.</i>					
DATE REC'D BY LOCAL REG. <i>Feb 14-1956</i>		REGISTRAR'S SIGNATURE <i>Charles W. Hastings</i>		24. FUNERAL DIRECTOR <i>Keith S. Tillonghty</i>	
				ADDRESS <i>East New Market, Md.</i>	

MARGIN RESERVED FOR BINDING

RECEIVED

FEB 23 1956

BUREAU V. S.

1729 CERTIFICATE OF DEATH

Reg. Dist. No. 176

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
13 TOWN <u>Cambridge</u>	1 day	OR TOWN <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
67 Cambridge Md. Hospital		417 Henry Street	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
(Type or Print) <u>CHARLES</u> <u>LEE</u> <u>BRANNOCK</u>		OF DEATH: <u>2</u> <u>14</u> <u>19 56</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
Male	White	Married	Oct. 6, 1896
9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
59 yrs.	Months Days	Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
Ins. Agent		Life Insurance	Dorchester County, Md.
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
EEdgar Brannock		Annie Brerewood West	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:
Yes <input checked="" type="checkbox"/> W. War 1		211-07-7197	Mrs. Dessie Brannock Cambridge, Md.
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
421. IMMEDIATE CAUSE (A) "Shock."			
ANTECEDENT CAUSE (B) Multiple infarcts - Spleen, Brain, Kidneys			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Atherosclerosis (marked) aorta.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Coronary artery thrombosis			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
2			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> M.	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10:10, 1956, to 2:14, 1956 that I last saw the deceased alive on 2:14, 1956, and that death occurred at 1030 P. M. from the causes and on the date stated above.			
SIGNATURE <u>W. J. Jones</u>		ADDRESS <u>Cambr. 222 Ave</u> DATE SIGNED <u>2/15/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
Burial		Dorchester Memorial Park	
DATE THEREOF		LOCATION (City, town, or county) (State)	
2-17-56		Cambridge Dorchester, Md.	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
Feb. 16, 1956		LeCompte Funeral Service Cambridge, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.

FEB 20 1956

RECEIVED

D

1730 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Cambridge</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>84 Washington St</u>				STREET ADDRESS (If rural give location) <u>84 Washington St</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>John Edward Burres</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb 12 19 56</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>March 18, 1872</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Dorchester County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>Samuel Burres</u>				14. MOTHER'S MAIDEN NAME: <u>Caroline Jenkins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Elenor Seymor, Cambridge, Md</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cardiac Decompensation</u>							
ANTECEDENT CAUSE (S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 29, 1953</u> , to <u>Feb. 12 1956</u> that I last saw the deceased alive on <u>Feb. 12, 1956</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>J. Edwin Fassett</u>		M. D. <u>227 Pine St-Camb., Md.</u>		DATE SIGNED <u>2-15-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/17/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Crapo Cemetery</u>		LOCATION (City, town, or county) (State) <u>Crapo, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb. 14, 1956</u>		REGISTRAR'S SIGNATURE <u>John H. H.</u>		24. FUNERAL DIRECTOR <u>H.M. St. Clair, Jr.</u>		ADDRESS <u>Cambridge, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

FEB 20 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1731
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01715
Reg. Dist.

No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Md. Hospital</u>				STREET ADDRESS (If rural, give location) <u>62 Park Lane</u>			
3. NAME OF DECEASED: (Type or Print) <u>Percy</u> <u>Cephas</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 16,</u> 19 <u>56</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>April 6, 1912</u>	
9. AGE last birthday: <u>43</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Oystering</u>		11. BIRTHPLACE (State or foreign country): <u>Dorchester County, Md.</u>	
13. FATHER'S NAME: <u>Edgar Cephas</u>				14. MOTHER'S MAIDEN NAME: <u>Nora Pritchett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>217-10-8102</u>		17. INFORMANT & ADDRESS: <u>Willie Cephas: Cambridge, Md.</u>			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>331X</u> Immediate cause (a) <u>Cerebral Hemorrhage</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating <u>underlying cause last</u> (c)						<u>24 hrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>. SIGNATURE <u>John M. Hays</u> M. D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>2/20/56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>2/20/56</u>		NAME OF CEMETERY OR CREMATORY <u>Waucho Cemetery</u>		LOCATION (City, town, or county) (State) <u>Dorchester Md.</u>	
DATE REC'D BY LOCAL REG. <u>Feb. 16, 1956</u>		REGISTRAR'S SIGNATURE <u>John M. Hays</u>		24. FUNERAL DIRECTOR <u>H.M. St. Clair</u>		ADDRESS <u>Cambridge, Md.</u>	

BUREAU V. S.

1958

RECEIVED

RECEIVED

1741 CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Dorchester		MARYLAND		STATE Maryland		COUNTY Dorchester	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
Hurlock - Rural		Life		Hurlock - Rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
Harrison Ferry				Harrison Ferry			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
Nellie Burke Christopher				February 12 1956			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
Female		White		Widowed		October 4, 1886	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
69 yrs.		Months Days Hours Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Housework				Home		Dorchester Co., Maryland	
12. CITIZEN OF WHAT COUNTRY?				U.S.A.			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Robert H. Conway				Jennie Medford			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
No				None		Maragert R. Simpson, Hurlock, Md., R.F.D.	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) 420.1 Coronary Thrombosis						1 hr.	
ANTECEDENT CAUSE (S) Hypertension & Chronic Myocarditis						10 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
0							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6/1, 1955 , to 2/12, 1956 that I last saw the deceased alive on 2/12, 1956 , and that death occurred at 7:15PM , from the causes and on the date stated above.							
SIGNATURE Frank M. Anderson				ADDRESS Federalsburg, Md.		DATE SIGNED 2/14/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Feb. 16, 1956		Saint Paul Cemetery		Hurlock, Maryland, R.F.D.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Feb 16 - 1956		Charles H. Hestings		J.J. Frampton and Son, Federalsburg, Md.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 23 1956

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1742 CERTIFICATE OF DEATH

01717

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		STATE <u>Delaware</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN <u>Middleton</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		STREET ADDRESS		(If rural give location)	
TOWN <u>Cambridge</u>		<u>19 Days</u>		<u>44x-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hosp</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>James</u> (Middle) <u>Fletcher</u> (Last) <u>Conner</u>				(Month) <u>Feb</u> (Day) <u>20</u> (Year) <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec 15 1870</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DIRT</u>		11. BIRTHPLACE (State or foreign country) <u>Del</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH B. CONNOR</u>				14. MOTHER'S MAIDEN NAME <u>RACHEL SHAHAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT & ADDRESS <u>Hosp Rec'ds Cambridge Md</u>			
(If Yes, give war or dates of service)							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
4500 IMMEDIATE CAUSE (A) <u>General Arteriosclerosis</u>						<u>UNK</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 1, 1956</u> , to <u>Feb 20, 1958</u> , that I last saw the deceased alive on <u>Feb 19, 1956</u> , and that death occurred at <u>1:18 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Thomas J. Dredge M.D.</u>				ADDRESS (Street, city, town, state) <u>Cambridge, Md</u>		DATE SIGNED <u>Feb 20 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>7/22/56</u>		NAME OF CEMETERY OR CREMATORY <u>BETHEL</u>		LOCATION (City, town, or county) (State) <u>CHESAPEAKE CITY MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>John Hall, R. D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge Md.</u>	
DATE <u>Feb 20, 1956</u>							

BUREAU V. S.

FEB 21 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1732 CERTIFICATE OF DEATH

01718

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>67 Cambridge Maryland Hospital</u>			d. STREET ADDRESS <u>409 Washington Street</u>		
3. NAME OF DECEASED (Type or print) First <u>LEILA</u> Middle <u>RIGGINS</u> Last <u>CREIGHTON</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>27</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 23, 1878</u>		9. AGE (In years last birthday) <u>78</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Golden Hill, Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Scott Riggins</u>			14. MOTHER'S MAIDEN NAME <u>Jane Shenton</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Emerson Creighton Cambridge, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>517x BRONCHIAL PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>- RESPIRATORY VIRUS INFECTION</u> DUE TO (c) <u>PARALYSIS OF RIGHT VOCAL CORD</u> <u>HEMORRHAGE INTO RIGHT LOBE OF THYROID GLAND</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CORONARY HEART DISEASE WITH HEMIPARESIS DUE TO CEREBRAL HEMORRHAGE</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>4-25-51</u> , 19 <u> </u> to <u>2-27-56</u> , 19 <u> </u> , that I last saw the deceased alive on <u>2-27-56</u> , 19 <u> </u> , and that death occurred at <u>4:30A</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Albert E. Bunker</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>9 Race St., Cambridge, Md., 2-29-56</u>			
PHYSICIAN'S NAME (Type) <u>ALBERT E. BUNKER, M. D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/1/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>	
				22d. LOCATION (City, town, or county) (State) <u>Cambridge Dorchester Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>			ADDRESS <u>Cambridge, Md.</u>		
24a. REC'D BY REGISTRAR DATE <u>March 1, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>John Ray, M.D.</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED MAYNARD		2. SEX MALE		3. AGE 27		4. DATE OF BIRTH JAN 10 1929		5. PLACE OF BIRTH BALTIMORE, MARYLAND	
6. OCCUPATION LABORER		7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL		9. DATE OF DEATH MAY 15 1956		10. PLACE OF DEATH HOME	
11. SIGNATURE OF PHYSICIAN J. H. SMITH		12. SIGNATURE OF REGISTRAR J. H. SMITH		13. SIGNATURE OF WITNESS J. H. SMITH		14. SIGNATURE OF WITNESS J. H. SMITH		15. SIGNATURE OF WITNESS J. H. SMITH	
16. SIGNATURE OF WITNESS J. H. SMITH		17. SIGNATURE OF WITNESS J. H. SMITH		18. SIGNATURE OF WITNESS J. H. SMITH		19. SIGNATURE OF WITNESS J. H. SMITH		20. SIGNATURE OF WITNESS J. H. SMITH	
21. SIGNATURE OF WITNESS J. H. SMITH		22. SIGNATURE OF WITNESS J. H. SMITH		23. SIGNATURE OF WITNESS J. H. SMITH		24. SIGNATURE OF WITNESS J. H. SMITH		25. SIGNATURE OF WITNESS J. H. SMITH	
26. SIGNATURE OF WITNESS J. H. SMITH		27. SIGNATURE OF WITNESS J. H. SMITH		28. SIGNATURE OF WITNESS J. H. SMITH		29. SIGNATURE OF WITNESS J. H. SMITH		30. SIGNATURE OF WITNESS J. H. SMITH	
31. SIGNATURE OF WITNESS J. H. SMITH		32. SIGNATURE OF WITNESS J. H. SMITH		33. SIGNATURE OF WITNESS J. H. SMITH		34. SIGNATURE OF WITNESS J. H. SMITH		35. SIGNATURE OF WITNESS J. H. SMITH	
36. SIGNATURE OF WITNESS J. H. SMITH		37. SIGNATURE OF WITNESS J. H. SMITH		38. SIGNATURE OF WITNESS J. H. SMITH		39. SIGNATURE OF WITNESS J. H. SMITH		40. SIGNATURE OF WITNESS J. H. SMITH	
41. SIGNATURE OF WITNESS J. H. SMITH		42. SIGNATURE OF WITNESS J. H. SMITH		43. SIGNATURE OF WITNESS J. H. SMITH		44. SIGNATURE OF WITNESS J. H. SMITH		45. SIGNATURE OF WITNESS J. H. SMITH	
46. SIGNATURE OF WITNESS J. H. SMITH		47. SIGNATURE OF WITNESS J. H. SMITH		48. SIGNATURE OF WITNESS J. H. SMITH		49. SIGNATURE OF WITNESS J. H. SMITH		50. SIGNATURE OF WITNESS J. H. SMITH	
51. SIGNATURE OF WITNESS J. H. SMITH		52. SIGNATURE OF WITNESS J. H. SMITH		53. SIGNATURE OF WITNESS J. H. SMITH		54. SIGNATURE OF WITNESS J. H. SMITH		55. SIGNATURE OF WITNESS J. H. SMITH	
56. SIGNATURE OF WITNESS J. H. SMITH		57. SIGNATURE OF WITNESS J. H. SMITH		58. SIGNATURE OF WITNESS J. H. SMITH		59. SIGNATURE OF WITNESS J. H. SMITH		60. SIGNATURE OF WITNESS J. H. SMITH	
61. SIGNATURE OF WITNESS J. H. SMITH		62. SIGNATURE OF WITNESS J. H. SMITH		63. SIGNATURE OF WITNESS J. H. SMITH		64. SIGNATURE OF WITNESS J. H. SMITH		65. SIGNATURE OF WITNESS J. H. SMITH	
66. SIGNATURE OF WITNESS J. H. SMITH		67. SIGNATURE OF WITNESS J. H. SMITH		68. SIGNATURE OF WITNESS J. H. SMITH		69. SIGNATURE OF WITNESS J. H. SMITH		70. SIGNATURE OF WITNESS J. H. SMITH	
71. SIGNATURE OF WITNESS J. H. SMITH		72. SIGNATURE OF WITNESS J. H. SMITH		73. SIGNATURE OF WITNESS J. H. SMITH		74. SIGNATURE OF WITNESS J. H. SMITH		75. SIGNATURE OF WITNESS J. H. SMITH	
76. SIGNATURE OF WITNESS J. H. SMITH		77. SIGNATURE OF WITNESS J. H. SMITH		78. SIGNATURE OF WITNESS J. H. SMITH		79. SIGNATURE OF WITNESS J. H. SMITH		80. SIGNATURE OF WITNESS J. H. SMITH	
81. SIGNATURE OF WITNESS J. H. SMITH		82. SIGNATURE OF WITNESS J. H. SMITH		83. SIGNATURE OF WITNESS J. H. SMITH		84. SIGNATURE OF WITNESS J. H. SMITH		85. SIGNATURE OF WITNESS J. H. SMITH	
86. SIGNATURE OF WITNESS J. H. SMITH		87. SIGNATURE OF WITNESS J. H. SMITH		88. SIGNATURE OF WITNESS J. H. SMITH		89. SIGNATURE OF WITNESS J. H. SMITH		90. SIGNATURE OF WITNESS J. H. SMITH	
91. SIGNATURE OF WITNESS J. H. SMITH		92. SIGNATURE OF WITNESS J. H. SMITH		93. SIGNATURE OF WITNESS J. H. SMITH		94. SIGNATURE OF WITNESS J. H. SMITH		95. SIGNATURE OF WITNESS J. H. SMITH	
96. SIGNATURE OF WITNESS J. H. SMITH		97. SIGNATURE OF WITNESS J. H. SMITH		98. SIGNATURE OF WITNESS J. H. SMITH		99. SIGNATURE OF WITNESS J. H. SMITH		100. SIGNATURE OF WITNESS J. H. SMITH	

BUREAU V. 3

MAR 6 1956

RECEIVED



DATA ON INTERVIEW OF
DECEASED'S NEAREST RELATIVE
TO BE FURNISHED TO BUREAU OF
VITAL STATISTICS BY
MAY 15 1956

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1743

01719
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 116

1. PLACE OF DEATH:

COUNTY Dorchester MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) Lakesville LENGTH OF STAY (in this place) Lifetime

HOSPITAL OR INSTITUTION OR STREET ADDRESS At Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Dorchester

CITY (If outside corporate limits write RURAL and give nearest town) Lakesville

STREET ADDRESS (If rural, give location) Rural

3. NAME OF DECEASED: (First) GEORGE (Middle) E. (Last) FOXWELL

4. DATE OF DEATH Feb. 20 1956

5. SEX: Male 6. COLOR OR RACE: White 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed 8. DATE OF BIRTH: Mar. 30, 1879 9. AGE last birthday: 76 yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Farmer 10b. KIND OF BUSINESS OR INDUSTRY: Farming 11. BIRTHPLACE (State or foreign country): Lakesville, Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Foxwell 14. MOTHER'S MAIDEN NAME: Sarah Jane Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) 16. SOCIAL SECURITY No.: None 17. INFORMANT & ADDRESS: Henry Foxwell Lakesville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

331X

Immediate cause (a) Cerebral Hemorrhage

DUE TO

Antecedent cause(s) (b) DUE TO

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

hrs.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☐

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

John M. [Signature]

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 2/22/56

DEPUTY MEDICAL EXAMINER ☒

M. D. ASSISTANT MEDICAL EXAM.

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Feb. 22, 1956John M. [Signature]LeCompte Funeral Service Cambridge, Md.

RECEIVED

FEB 23 1956

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01720

1744 CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY Dorchester CITY (If outside corporate limits, write RURAL OR and give nearest town) Cambridge TOWN X HOSPITAL OR INSTITUTION OR STREET ADDRESS Eastern Shore State Hospital				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Talbot CITY (If outside corporate limits, write RURAL and give nearest town) Pilghman OR Town TOWN 20X-2 STREET ADDRESS (If rural give location) ✓			
3. NAME OF DECEASED (Type or Print) Calvin (First) Gibson (Middle) Gibson (Last)				4. DATE OF DEATH (Month) Feb. (Day) 13 (Year) 1956 19			
5. SEX M	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 9/26/1882	9. AGE last birthday 73 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder		10b. KIND OF BUSINESS OR INDUSTRY Carpentry		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob H. Gibson				14. MOTHER'S MAIDEN NAME Julia A. Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-03-0803		17. INFORMANT & ADDRESS Eastern Shore State Hospital Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.2 IMMEDIATE CAUSE (A) Chronic Myocarditis ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) STATING UNDERLYING CAUSE LAST. DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH several yrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Dementia Praecox, paranoid type				about 18 yrs.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 1 , 19 51 , to Feb. 13 , 19 56 , that I last saw the deceased alive on Feb. 12 , 19 56 , and that death occurred at 2:35 A.M. from the causes and on the date stated above.							
SIGNATURE Robert H. Reddick				ADDRESS (Street, city, town, state) M.D. State Hospital, Cambridge, Md.		DATE SIGNED 2/13/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	DATE THEREOF FEB 15 1956	NAME OF CEMETERY OR CREMATORY HOLY AND DEER CEM		LOCATION (City, town, or county) (State) 4430 BELLAIR RD MD			
24. REC'D BY REGISTRAR Feb. 16, 1956	REGISTRAR'S SIGNATURE John Mace, Jr.		25. FUNERAL DIRECTOR'S SIGNATURE Walter B...		ADDRESS 7110 BELAIR RD		

RECEIVED

01721

MARYLAND

STATE DEPARTMENT OF HEALTH

1745 CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dor</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hurlock</u> <u>All life</u> (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hurlock</u> <u>md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Malcolm</u> (First) <u>Carrol</u> (Middle) <u>Hastings</u> (Last)		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>4</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>12/8/1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant Own Store</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>51</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles W. Hastings</u>		14. MOTHER'S MAIDEN NAME <u>Deissy Mowbray</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>180-10-2765</u>	
17. INFORMANT AND ADDRESS <u>Mrs Malcolm Hastings</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(a) Immediate cause <u>420.1 Coronary Occlusion</u>		<u>4 hours</u>	
(b) Antecedent cause(s) <u>Coronary Artery Disease</u>		<u>3 years</u>	
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1953</u> , 19....., to <u>2/4</u> , 195 <u>6</u> that I last saw the deceased alive on <u>2/4</u> , 19 <u>56</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>W. Harrison</u> (Degree or title) <u>MD</u>		ADDRESS <u>Hurlock Md.</u> DATE SIGNED <u>2/7/56</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> DATE <u>2/7/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Washington</u> LOCATION (City, town, or county) <u>Hurlock, md</u>	
DATE REC'D BY LOCAL REG. <u>2-7-1956</u> REGISTRAR'S SIGNATURE <u>Charles Hastings</u>		24. FUNERAL DIRECTOR <u>W. S. Halliday</u> ADDRESS <u>East 2nd Street</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. B.

FEB 14 1956

RECEIVED

1
C
M
1
2
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and cemetery official must be signed by the attending physician and cemetery official. After the death certificate has been signed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1733

CERTIFICATE OF DEATH

Reg. Dist. No. 116

01722

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>67 Cambridge Md. Hospital</u>		d. STREET ADDRESS <u>203 Henry Street</u>	
3. NAME OF DECEASED (Type or print) First <u>CHRISTINA</u> Middle <u>L.</u> Last <u>INSLEY</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 1, 1956</u>
9. AGE (In years last birthday) <u>0</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>26</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None-Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Cambridge, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edgar Insley</u>		14. MOTHER'S MAIDEN NAME <u>Mary Short</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Edgar Insley</u>		Address <u>Cambridge, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Broncho pneumonia</u> <u>756.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mania</u> DUE TO (c) <u>Congenital Anomalies of G.I. tract</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>26 days</u> <u>26 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(autopsy - unreported)</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>2-1</u> , 19 <u>56</u> , to <u>2-26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-26</u> , 19 <u>56</u> , and that death occurred at <u>12:50 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>15 Locust Street, Cambridge, Maryland</u> DATE SIGNED <u>Eldridge H. Wolff, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/28/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>East New Market Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>East New Market, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Md.</u>	
24a. REC'D BY REGISTRAR <u>Feb 28 56</u>		24b. REGISTRAR'S SIGNATURE <u>John H. D.</u>	

2067287386

1746

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Worcester</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Talbot</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<i>X</i> TOWN		TOWN <i>St. Michaels Md 209-2</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Nursing Home, Machow Md</i>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<i>Ladie Jackson</i>		OF DEATH: <i>Feb. 4 1956</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>widowed</i>	8. DATE OF BIRTH: <i>Feb. 15- 1871</i>
9. AGE last birthday <i>84</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <i>St. Michaels Md</i>
12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>		13. FATHER'S NAME: <i>Henry Burrows</i>	
14. MOTHER'S MAIDEN NAME: <i>Fannie Sears</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT & ADDRESS: <i>Otto Fairbank, St. Michaels Md.</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Coronary Thrombosis</i>			<i>30 MIN.</i>
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<i>0</i>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>25 JAN 54</i> to <i>4 Feb 56</i> , that I last saw the deceased alive on <i>1 Feb 1956</i> and that death occurred at <i>5:00 A.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Hattie E. Gundy</i>		DATE SIGNED <i>6 Feb. 56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2/7/56</i>	
NAME OF CEMETERY OR CREMATORY <i>Christ Cemetery</i>		LOCATION (City, town, or county) (State) <i>St. Michaels Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Feb. 1, 1956</i>		REGISTRAR'S SIGNATURE <i>W. H. D. Hamilton</i>	
24. FUNERAL DIRECTOR <i>Hamilton</i>		ADDRESS <i>St. Michaels Md</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 8 1956

RECEIVED

Mr. Gandy

PLANKS

1734 CERTIFICATE OF DEATH

Reg. Dist. No. 116

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
13 TOWN <u>Cambridge</u>		1 Week		13 TOWN <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
90 Passwaters Conv. Home				313 West End Ave			
3. NAME OF DECEASED: (First)		(Middle)		(Last)		4. DATE (Month) (Day) (Year)	
DECEASED: (Type or Print) JOSEPH		H.		JENKINS		OF DEATH: 2 12 19 56	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Married	8/7/1876	79 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Waterman		Seafood		Mathews County, Va.		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
James Jenkins				Alice Evans			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
No		212-16-129		Mrs. Elizabeth Jenkins Cambridge, Md.			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) <u>Central Hemorrhage</u>							
ANTECEDENT CAUSE (B) <u>central arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Senility</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
0							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12/6, to 2/12, 1956, that I last saw the deceased alive on 2/12, 1956, and that death occurred at 3:4 M, from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS		DATE SIGNED	
<u>W. B. Banks</u>		M. D. <u>Cambridge Md</u>		<u>2/13/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		2-14-56		Dorchester Memorial Park		Cambridge Dorchester Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Feb. 14, 1956		<u>J. H. Pace, M. D.</u>		LeCompte Funeral Service		Cambridge, Md.	

BUREAU V. S.

FEB 16 1956

RECEIVED

1735

CERTIFICATE OF DEATH

Reg. Dist. No. 112

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>				d. STREET ADDRESS <u>Rural</u>			
3. NAME OF DECEASED (Type or print) First <u>PEARL</u> Middle <u>MAY</u> Last <u>RIGGINS JENKINS</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 - 16 - 1900</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Golden Hill, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Hicks Riggins</u>			14. MOTHER'S MAIDEN NAME <u>Ada Slacum</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mr. Alonza M. Jenkins</u> Address <u>Golden Hill, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Heart Disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/26/56</u> to <u>2/29/56</u> , that I last saw the deceased alive on <u>2/29</u> , 19 <u>56</u> , and that death occurred at <u>11 5/2</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>136 Race St. Cambridge, Md.</u> DATE SIGNED <u>3/2/56</u>							
ACTUAL SIGNATURE <u>Lawrence Maryanov</u> M.D. <u>136 Race St. Cambridge, Md.</u>							
PHYSICIAN'S NAME (Type) <u>Lawrence Maryanov</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/3/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Dorchester Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u> <u>Per. J. E. D.</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>March 3 '56</u>	
				24b. REGISTRAR'S SIGNATURE <u>John H. H. H.</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and cemetery registrar must be filled in by the funeral director. After the certificate has been signed by the attending physician and cemetery registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MD.		MARYLAND	
NAME OF DECEASED _____		SEX _____	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
DATE OF DEATH _____		TIME OF DEATH _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF REGISTRAR _____	
OFFICIAL USE _____		OFFICIAL USE _____	

BUREAU V. S.

MAR 6 1956

RECEIVED

RECEIVED
 MAR 10 1956
 BALTIMORE, MD.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1747

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 110

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN <u>Hurlock - Rural</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Hurlock - Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Petersburg</u>				STREET ADDRESS (If rural, give location) <u>Petersburg</u>			
3. NAME OF DECEASED: (First) <u>Charles</u>		(Middle) <u>Winfield</u>		(Last) <u>Jolley</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>February 14 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Jan. 23, 1884</u>		9. AGE last birthday: <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired Laborer-American Stores</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Cannery</u>		11. BIRTHPLACE (State or foreign country): <u>Dorchester Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James Jolley</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Sampson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>216-10-1665</u>		17. INFORMANT & ADDRESS: <u>Catherine E. Jolley, Hurlock, Md., R.F.D.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>43a.1</u> Immediate cause (a)..... <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c).....							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>Joan Moore J.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED _____ M. D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 2/15/56 ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Feb. 19, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Petersburg Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hurlock, Md., R.F.D.</u>	
DATE REC'D BY LOCAL REG. <u>Feb 19-1956</u>		REGISTRAR'S SIGNATURE <u>Chas W Hastings</u>		24. FUNERAL DIRECTOR <u>J.J. Frampton and Son, Federalburg, Md.</u>		ADDRESS	

01726

BUREAU V. 3

FEB 28 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01728

1736

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
13 TOWN <u>Cambridge</u>		20 Years		OR TOWN <u>Cambridge</u> 13			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>AT HOME 217 High Street</u>				STREET ADDRESS (If rural give location) <u>217 High Street</u> 1			
3. NAME OF DECEASED: (First) <u>MARY</u>		(Middle) <u>LEWIS</u>		(Last) <u>JONES</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>2</u> <u>11</u> <u>1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>3/4/1867</u>	9. AGE last birthday <u>88</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>Near Vienna, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Levin B. Lewis</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Marshall</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT & ADDRESS: <u>Addie Lewis 217 High St. Cambridge, Md.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma of jaws with metastasis</u>							<u>8 mos.</u>
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerotic HT, Disease</u>							<u>5 yrs</u>
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/25</u> <u>1954</u> , to <u>2/11</u> <u>1956</u> , that I last saw the deceased alive on <u>2/10</u> <u>1956</u> , and that death occurred at <u>2:30</u> <u>A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Alfred R. Maryanov</u>		M.D. <u>136 Race St. Cambridge</u>		ADDRESS <u>2/14/56</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/13/56</u>		NAME OF CEMETERY OR CREMATORY <u>Antioch Churchyard</u>		LOCATION (City, town, or county) (State) <u>R.F.D. #1 Cambridge, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb. 13, 1956</u>		REGISTRAR'S SIGNATURE <u>John R. ...</u>		24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Md.</u>	

RECEIVED

FEB 16 1956

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01729

1737 CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Dorchester		MARYLAND		STATE Maryland		COUNTY Dorchester	
CITY (If outside corporate limits, write RURAL and give nearest town) Cambridge		LENGTH OF STAY (in this place) 30 years		CITY (If outside corporate limits, write RURAL and give nearest town) Cambridge			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 18 Muir Street				STREET ADDRESS (If rural give location) 18 Muir Street			
3. NAME OF DECEASED (First) (Middle) (Last) Wilda Virginia Gillis Langford				4. DATE OF DEATH (Month) (Day) (Year) Feb. 3rd 19 56			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 4-12-83		9. AGE last birthday 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY domestic		11. BIRTHPLACE (State or foreign country) Wicomico County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cassius S. Gillis				14. MOTHER'S MAIDEN NAME Margaret Bennett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Mr. Frank Langford, Cambridge, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
260x IMMEDIATE CAUSE (A) Terminal Broncho-pneumonia						24 hours	
ANTECEDENT CAUSE(S) DUE TO (B) Diabetic acidosis						48 hours	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Diabetes Mellitus						5 years +	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. renal disease						5 years +	
19a. DATE OF OPERATION -- -- --		19b. MAJOR FINDINGS OF OPERATION -- -- --					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) -- -- --		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) -- -- --		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) -- -- --		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? -- -- --			
22. I hereby certify that I attended the deceased from 2-1-65 , 19 65 , to 2-3-56 , 19 56 , that I last saw the deceased alive on 2-2-56 , 19 56 , and that death occurred at 3:00AM , from the causes and on the date stated above.							
SIGNATURE <i>Eldridge H. Wolff</i>				ADDRESS (Street, city, town, state) Cambridge, Maryland		DATE SIGNED 2-4-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2-5-56		NAME OF CEMETERY OR CREMATORY Cambridge Cemetery		LOCATION (City, town, or county) (State) Cambridge - Dorchester Md	
24. REC'D BY REGISTRAR DATE Feb 3, 1956		REGISTRAR'S SIGNATURE <i>John H. New</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Le Compte Funeral Service, Cambridge, Md.			

BUREAU V. S.

FEB 9 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1748 CERTIFICATE OF DEATH

01730

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Ma ryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Cambridge, R.D.</u>		<u>50 years</u>		TOWN <u>Cambridge R.D.</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rural</u>				STREET ADDRESS (If rural give location) <u>Rural</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Pearl</u>		(Middle) <u>Miranda</u>		(Last) <u>Parks</u>		<u>Feb. 15, 1956</u> 19	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Aug. 28, 1876</u>	<u>79</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Somerset County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Wesley Ford</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs. R. Hernie Creighton, R.D. 2 Cambridge,</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Uremia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Congestive Heart Failure</u>				<u>2 weeks</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerosis & hypertension</u>				<u>?</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes mellitus</u>				<u>15 yrs</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20/ AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 14, 1956</u> to <u>Feb. 15, 1956</u> , that I last saw the deceased alive on <u>Feb. 14, 1956</u> , and that death occurred at <u>4:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. H. Thompson</u>				ADDRESS (Street, city, town, state) <u>Cambridge Md</u>		DATE SIGNED <u>Feb 14, 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 17, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>John Hall</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. O. Kenneth R. Howard</u>		ADDRESS <u>Cambridge, Md.</u>	
DATE <u>Feb. 17, 1956</u>							

1934 CERTIFICATE OF DEATH

Case No. _____

1. NAME OF DECEASED _____

2. SEX _____

3. AGE _____

4. OCCUPATION _____

5. PLACE OF BIRTH _____

6. DATE OF BIRTH _____

7. PLACE OF DEATH _____

8. CAUSE OF DEATH _____

9. MEDICAL HISTORY _____

10. DATE OF DEATH _____

11. SIGNATURE OF PHYSICIAN _____

12. SIGNATURE OF REGISTRAR _____

13. SIGNATURE OF WITNESS _____

14. SIGNATURE OF DECEASED _____

15. SIGNATURE OF NEXT OF KIN _____

16. SIGNATURE OF _____

17. SIGNATURE OF _____

18. SIGNATURE OF _____

19. SIGNATURE OF _____

20. SIGNATURE OF _____

21. SIGNATURE OF _____

22. SIGNATURE OF _____

23. SIGNATURE OF _____

24. SIGNATURE OF _____

25. SIGNATURE OF _____

26. SIGNATURE OF _____

27. SIGNATURE OF _____

28. SIGNATURE OF _____

29. SIGNATURE OF _____

30. SIGNATURE OF _____

31. SIGNATURE OF _____

32. SIGNATURE OF _____

33. SIGNATURE OF _____

34. SIGNATURE OF _____

35. SIGNATURE OF _____

36. SIGNATURE OF _____

37. SIGNATURE OF _____

38. SIGNATURE OF _____

39. SIGNATURE OF _____

40. SIGNATURE OF _____

41. SIGNATURE OF _____

42. SIGNATURE OF _____

43. SIGNATURE OF _____

44. SIGNATURE OF _____

45. SIGNATURE OF _____

46. SIGNATURE OF _____

47. SIGNATURE OF _____

48. SIGNATURE OF _____

49. SIGNATURE OF _____

50. SIGNATURE OF _____

51. SIGNATURE OF _____

52. SIGNATURE OF _____

53. SIGNATURE OF _____

54. SIGNATURE OF _____

55. SIGNATURE OF _____

56. SIGNATURE OF _____

57. SIGNATURE OF _____

58. SIGNATURE OF _____

59. SIGNATURE OF _____

60. SIGNATURE OF _____

61. SIGNATURE OF _____

62. SIGNATURE OF _____

63. SIGNATURE OF _____

64. SIGNATURE OF _____

65. SIGNATURE OF _____

66. SIGNATURE OF _____

67. SIGNATURE OF _____

68. SIGNATURE OF _____

69. SIGNATURE OF _____

70. SIGNATURE OF _____

71. SIGNATURE OF _____

72. SIGNATURE OF _____

73. SIGNATURE OF _____

74. SIGNATURE OF _____

75. SIGNATURE OF _____

76. SIGNATURE OF _____

77. SIGNATURE OF _____

78. SIGNATURE OF _____

79. SIGNATURE OF _____

80. SIGNATURE OF _____

81. SIGNATURE OF _____

82. SIGNATURE OF _____

83. SIGNATURE OF _____

84. SIGNATURE OF _____

85. SIGNATURE OF _____

86. SIGNATURE OF _____

87. SIGNATURE OF _____

88. SIGNATURE OF _____

89. SIGNATURE OF _____

90. SIGNATURE OF _____

91. SIGNATURE OF _____

92. SIGNATURE OF _____

93. SIGNATURE OF _____

94. SIGNATURE OF _____

95. SIGNATURE OF _____

96. SIGNATURE OF _____

97. SIGNATURE OF _____

98. SIGNATURE OF _____

99. SIGNATURE OF _____

100. SIGNATURE OF _____

101. SIGNATURE OF _____

BUREAU V. S.

FEB 20 1934

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1749
CERTIFICATE OF DEATH

01731

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Vienna R.F.D. # 1</u>				c. LENGTH OF STAY IN 1b <u>5 Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At Home</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>W.</u> Last <u>READ</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 14, 1873</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Household</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John H. C. Brewer</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Cummings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mr. Fred W. Walker</u> Address <u>Vienna, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 HOURS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour _____ p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>MARCH 9</u> , 19 <u>51</u> , to <u>FEBRUARY 17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>FEBRUARY 17</u> , 19 <u>56</u> , and that death occurred at <u>10:30 A</u> .M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>24 Feb. 56</u> ACTUAL SIGNATURE <u>Walter E. Gunby Jr.</u> PHYSICIAN'S NAME (Type) <u>Walter E. Gunby Jr.</u> <u>105 Church Street Cambridge Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/27/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>Cambridge Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Feb 25, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>John Thae, M.D.</u>			

CERTIFICATE OF DEATH

2-25-1936

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		PLACE OF INTERMENT [Faint text]		NAME OF FUNERAL HOME [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CLERK [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF JUDGE [Faint text]	

BUREAU V. S.

FEB 28 1936

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE DESTROYED OR DISPOSED OF IN ANY MANNER WITHOUT THE APPROVAL OF THE STATE DEPARTMENT OF HEALTH.

01732

MARYLAND

STATE DEPARTMENT OF HEALTH

1750

CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH COUNTY <u>Dorchester</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dorchester</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place) <u>4 mo.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dor</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge Pt.</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Peter John Roeder</u>		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>5</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Single</u>	8. DATE OF BIRTH <u>12/25/1882</u>	9. AGE last birthday <u>73</u> yrs.	10. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OR WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Roeder</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Utech</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS <u>Mrs Susanna Kleisch</u>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>163X Immediate cause (a)..... Carcinoma of lung</u> Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)..... (c).....				<u>1 yr +</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>December 5, 1955</u> to <u>Feb. 5, 1956</u> , that I last saw the deceased alive on <u>2/5, 1956</u> , and that death occurred at <u>12:30 P.M.</u> , from the causes and on the date stated above.					
SIGNATURE <u>W. A. Harrison</u>		(Degree or title) <u>M.D.</u>		ADDRESS <u>Dorchester, Md.</u>	
DATE SIGNED <u>2/7/56</u>					
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE <u>2/8/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Dor. Memorial</u>	
LOCATION (City, town, or county) <u>Cambridge, Md.</u>		24. FUNERAL DIRECTOR <u>H.B. Halloway</u>		ADDRESS <u>East New Market.</u>	
DATE REC'D BY LOCAL REG. <u>2-8-1956</u>		REGISTRAR'S SIGNATURE <u>Chas. W. Hastings</u>			

MARGIN RESERVED FOR BINDING

BUREAU VI. 31

FEB 14 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1751
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01733
Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Rhodesdale</u>		LENGTH OF STAY (in this place) <u>6 years</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Rhodesdale</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Main Highway</u>				STREET ADDRESS (If rural, give location) <u>Main Highway</u>			
3. NAME OF DECEASED: (First) <u>Major</u> (Middle) <u>Colonna</u> (Last) <u>Slacum</u>				4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>8</u> (Year) <u>1956</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>May 13, 1876</u>	9. AGE last birthday: <u>79</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired Contractor self-employed</u>			10b. KIND OF BUSINESS OR INDUSTRY: _____		11. BIRTHPLACE (State or foreign country): <u>Cambridge, R.D.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME: <u>Levin L. Slacum</u>				14. MOTHER'S MAIDEN NAME: <u>Dorothy Hubbard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Charles G. Slacum, Race St., Cambridge, Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>422.1</u> Immediate cause (a) <u>Cerebral Vascular Accident</u> DUE TO						<u>1 day</u>	
Antecedent cause(s) (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)						<u>10 yrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE <u>John M. [Signature]</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2/10/56</u>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Feb. 11, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
DATE REC'D BY LOCAL REG. <u>Feb. 10, 1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Kenneth R. Thomas, Cambridge, Md.</u>		ADDRESS	

BUREAU V. S.

FEB 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01734

1738

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u>				c. LENGTH OF STAY IN 1b <u>one week</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>47 Cambridge Md. Hospital</u>				d. STREET ADDRESS <u>Rural</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>STEWART</u> Last <u>STARK</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>25</u> Year <u>1956</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/22/1888</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Masonry Const.</u>		11. BIRTHPLACE (State or foreign country) <u>Glasgow, Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>George Stark</u>				14. MOTHER'S MAIDEN NAME <u>Jane Milgoley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>World War I</u>		17. INFORMANT Address <u>Mrs. Hilda K. Stark Woolfords, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric thrombosis</u> <u>570.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Venous occlusion</u> DUE TO (c) <u>Paralytic ileus</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 days</u> <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of head of pancreas</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. — 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 21, 1956</u> , to <u>Feb 25, 1956</u> , that I last saw the deceased alive on <u>Feb 25, 1956</u> , and that death occurred at <u>10:25 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lewis M. Burdette</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Locust St., Cambridge, Md. 2/25/56</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Lewis M. Burdette</u>				City Office Bldg., Cambridge, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 27, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Pk.</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Dorchester Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>Cambridge, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>Feb. 27, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>John H. H. H.</u>			

CERTIFICATE OF DEATH

1988

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. S.

FEB 28 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01735

1752

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cambridge</u>		<u>6/14/55</u>		TOWN <u>Denton</u>		<u>05X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Amanda</u>		(Middle) <u>Lee</u>		(Last) <u>Thorpe</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widowed</u>		8. DATE OF BIRTH <u>6/18/1870</u>	
9. AGE last birthday <u>85</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Wooten</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ann Andrews</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If Yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Eastern Shore State Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Generalized Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>several years</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Senile Psychosis</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/14</u> 19 <u>55</u> , to <u>2/18</u> 19 <u>56</u> , that I last saw the deceased alive on <u>2/18</u> 19 <u>56</u> , and that death occurred at <u>2:08 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert H. Reddick</u>		M.D. <u>State Hospital, Cambridge, Md.</u>		DATE SIGNED <u>2/18/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/21/56</u>		NAME OF CEMETERY OR CREMATORY <u>Burrsville</u>		LOCATION (City, town, or county) (State) <u>Burrsville, Md.</u>	
24. REC'D BY REGISTRAR <u>John H. H. J. E. Bouclair</u>		REGISTRAR'S SIGNATURE <u>John H. H. J. E. Bouclair</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John H. H. J. E. Bouclair</u>		ADDRESS <u>Greenboro, Md.</u>	
DATE <u>Feb 21, 1956</u>							

RECEIVED

RECEIVED
FEB 23 1956
BUREAU V. S.

CERTIFICATE OF DEATH

INVESTIGATION AND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1. NAME OF DECEASED [Name]		2. PLACE OF BIRTH [Place]	
3. SEX [Sex]		4. RACE [Race]	
5. DATE OF BIRTH [Date]		6. DATE OF DEATH [Date]	
7. TIME OF DEATH [Time]		8. PLACE OF DEATH [Place]	
9. CAUSE OF DEATH [Cause]		10. MANNER OF DEATH [Manner]	
11. SIGNATURE OF DECEASED [Signature]		12. SIGNATURE OF WITNESS [Signature]	
13. SIGNATURE OF PHYSICIAN [Signature]		14. SIGNATURE OF CORONER [Signature]	
15. SIGNATURE OF JUDGE [Signature]		16. SIGNATURE OF CLERK [Signature]	

RECEIVED
FEB 23 1956
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01736

1753 CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>rural-Cambridge</u>				TOWN <u>Salisbury</u>		<u>22-12-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>				STREET ADDRESS (If rural give location) <u>104 W. Chestnut</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Lloyd William Tilghman</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 23 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Wid</u>	8. DATE OF BIRTH <u>June 27, 1896</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Tilghman</u>				14. MOTHER'S MAIDEN NAME <u>Nora Reddish</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Eastern Shore State Hospital records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
421.4 IMMEDIATE CAUSE (A) <u>Chronic Endocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 15 1955</u> to <u>Feb 23 1956</u> , that I last saw the deceased alive on <u>Feb 23 1956</u> , and that death occurred at <u>9:03P</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Thomas J. Dredge</u> M.D.				ADDRESS (Street, city, town, state) <u>E.S.S. Hospital, Cambridge, Md.</u> DATE SIGNED <u>Feb 23 '56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 26, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
24. REC'D BY REGISTRAR <u>MAR 1 1956</u>		REGISTRAR'S SIGNATURE <u>Dr. John Mace, Jr.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hollingsworth</u>		ADDRESS <u>Salisbury Md.</u>	

Item 7, Film G19, 3-23-56 et.

1739

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <u>Cambridge</u>		<u>life</u>		TOWN <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>RFD #2</u>			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
<u>Ernest</u>		<u>Henry</u>		<u>Whittington</u>			
4. DATE OF DEATH: (Month) (Day) (Year)		<u>Feb</u>		<u>8</u>		<u>1956</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>April 2, 1877</u>	
9. AGE last birthday: <u>78</u> yrs.		IF UNDER 1 YEAR: Months Days		IF UNDER 24 HRS.: Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Blacksmith</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Blacksmithing</u>		11. BIRTHPLACE (State or foreign country): <u>Dor-County-Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Thomas H. Whittington</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Ann Eves</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>unk</u>		16. SOCIAL SECURITY NO.: <u>unk</u>		17. INFORMANT & ADDRESS: <u>Lela Whittington, RFD #2 Camb., Md.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0							
IMMEDIATE CAUSE				(A) <u>Cardiac Decompensation</u>			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <u>Hypertensive Arteriosclerotic heart disease</u>			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OR INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept</u> , 19 <u>55</u> to <u>Feb 8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb. 8</u> , 19 <u>56</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
SIGNATURE		<u>J. Edwin Fassett,</u>		M.D. <u>227 Pine St-Camb., Md.</u>		<u>-2-13-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2-12-56</u>		<u>Cordtown Cemetery</u>		<u>Cordtown, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Feb 12, 1956</u>		<u>John H. H. D.</u>		<u>H.M. StClair, Jr</u>		<u>High St-Camb., Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V.

FEB 20 1956

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01739

1754

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		STATE <u>Maryland</u> COUNTY <u>Kent</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		LENGTH OF STAY (In this place) <u>since 1/3/35</u>		OR TOWN <u>Chestertown</u>		STREET ADDRESS (If rural give location) <u>14-37-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>				STREET ADDRESS (If rural give location) <u>Chestertown</u>			
3. NAME OF DECEASED (Type or Print) <u>Elena Frances Wood</u>				4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>6</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>9/23/15</u>		9. AGE last birthday <u>40</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Walter Wood</u>			
14. MOTHER'S MAIDEN NAME <u>Elena Meyer</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>			
16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT'S ADDRESS <u>Eastern Shore State Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
150X IMMEDIATE CAUSE (A) <u>Carcinoma of Esophagus</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Dementia Praecox, hebephrenic type</u>				20 years			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C) <u>Dementia Praecox, hebephrenic type</u>				20 years			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 1</u> , 19 <u>51</u> , to <u>Feb. 6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb. 6</u> , 19 <u>56</u> , and that death occurred at <u>8:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert H. Reddick</u>				DATE SIGNED <u>2/6/56</u>			
ADDRESS (Street, city, town, state) <u>M.D. State Hospital, Cambridge, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2/9/56</u>		NAME OF CEMETERY OR CREMATORY <u>CHESTER CEM.</u>		LOCATION (City, town, or county) <u>CHESTERTOWN MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>J. H. Thae</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Willis Wells</u>		ADDRESS <u>Chestertown MD</u>	
DATE <u>Feb 8 1956</u>							

CERTIFICATE OF DEATH

File No. _____

1. Name of deceased _____

2. Sex _____

3. Date of birth _____

4. Date of death _____

5. Place of death _____

6. Cause of death _____

7. Manner of death _____

8. Signature of physician _____

9. Signature of registrar _____

10. Signature of coroner _____

11. Signature of medical examiner _____

12. Signature of health officer _____

13. Signature of _____

14. Signature of _____

BUREAU V. 2

FEB 9 1955

RECEIVED

NOTIFICATION

1. Name of deceased _____
2. Sex _____
3. Date of birth _____
4. Date of death _____
5. Place of death _____
6. Cause of death _____
7. Manner of death _____
8. Signature of physician _____
9. Signature of registrar _____
10. Signature of coroner _____
11. Signature of medical examiner _____
12. Signature of health officer _____
13. Signature of _____
14. Signature of _____